

STATEMENT OF CLAIM

1. At all material times the Plaintiff was the rider of motorcycle JLX215 [**“the motorcycle”**] and the Defendant was the driver and having control of motorcar SFJ1223T [**“the motorcar”**].
2. On or about 24 July 2017 at about 10.40am the Plaintiff was riding the motorcycle along Seletar Expressway [SLE] towards the direction of Bukit Timah Expressway [BKE]. SLE is a dual carriage highway with 3 lanes on the side of travel by the Plaintiff. While the Plaintiff was travelling along the extreme right lane of SLE, the motorcycle collided into the rear of the motorcar driven by the Defendant. At the material time the motorcar was either moving very slowly or had come to a stop thereby presenting itself as a nuisance and obstructing normal flow of traffic on the extreme right lane. As a result of the collision, the Plaintiff sustained serious injuries.
3. The said accident was caused solely by the negligence of the Defendant in the driving and management of the motorcar and/or nuisance.

PARTICULARS

- a) Driving at a very slow speed or being stationary on the extreme right lane [fast lane] of the highway;
- b) Posing as a nuisance and obstructing normal flow of traffic along the highway;
- c) Failing to exercise due care and skill in the management and control of the motorcar;

- d) Failing to observe the presence and approach of the Plaintiff on the motorcycle;
 - e) Failing to give a clear and unobstructed travel path to the Plaintiff who was proceeding straight along the fast lane of the highway in a normal manner;
 - f) Allowing the motorcar to remain on the fast lane which was unsafe and dangerous so to do;
 - g) Failing to take all reasonable steps to alert other road users that the motorcar poses a danger;
 - h) Causing a nuisance by failing to remove the motorcar from the fast lane;
 - i) Failing to stop, swerve, slow down or in any other way to manage or control the motorcar so as to avoid the said collision.
4. By reason of the matters aforesaid, the motorcycle was damaged and the Plaintiff sustained personal injuries, endured pain and has been put to loss and expense.

PARTICULARS OF PERSONAL INJURIES

The Plaintiff was born on 30.10.1992 and at the date of accident was 26 years old. A copy of the medical reports on the injuries sustained by the Plaintiff obtained to-date are annexed hereto:-

- 1. Memorandum dated 14 September 2017 from Dr Lim Jia Qing of Khoo Teck Puat Hospital (KTPH);
- 2. Medical report dated 24 September 2019 from Dr Lin Yingcui Annette of KTPH;
- 3. Medical report dated 26 September 2019 from Dr Jeffrey Leow of KTPH;

4. Medical report dated 14 October 2019 from Dr Lynn Thwin of KTPH;
5. Medical report dated 29 October 2019 from Dr Kang Minli of KTPH;
6. Medical report dated 23 October 2018 from Hospital Shah Alam;
7. Medical report dated 3 June 2019 from Universiti Kebangsaan Malaysia (UKM);
8. Medical report dated 29 May 2019 from Dr Ainul Syahrilfazli Jaafar of UKM;
9. Medical report dated 23 July 2019 from UKM;
10. Medical report dated 8 January 2019 from Dr Lim Li Yi of UKM;
11. Medical report dated 19 July 2019 from Dr Nor Hazla Mohamed Haflah of UKM.

Further particulars of personal injuries of the Plaintiff will be adduced at the trial or at such time when they become available.


PARTICULARS OF SPECIAL DAMAGES

A statement of special damages pursuant to Order 18 Rule 12A (1A) of the Rules of Court is annexed hereto.

And the Plaintiff claims:-

1. Damages;
2. Interest thereon at such rate and for such period as the Court may deem just;
3. Costs.

Dated and delivered this 1 July 2020



Solicitors for the Plaintiff

CENTRAL CHAMBERS LAW CORPORATION
Ref: RKC/uk/200200 [Dave Anan (DannyRaj)]

This Writ is issued by CENTRAL CHAMBERS LAW CORPORATION of 150 Cecil Street, #03-00, Singapore 069543, solicitors for the Plaintiff who resides at No. 1 Jalan Mulia 4, Taman Mulia, 42700 Banting, Selangor, Malaysia.

This Writ was served by way of personal service (or as may be) (state manner of service or in accordance with the terms of an order for substituted service) on the Defendant (who is known to me) (or who was pointed out to me by (or who admitted to me that he was at

on the day of 2020 at am/pm.

Indorsed the day of 2020.

Process Server

**PARTICULARS OF SPECIAL DAMAGES LODGED PURSUANT
TO ORDER 18 RULE 12(1A)(b) OF THE RULES OF COURT**

| | |
|--|----------------|
| 1. Medical expenses incurred in Singapore till to-date (and continuing) | S\$246,449.01 |
| 2. Medical expenses incurred in Malaysia till to-date (and continuing) | RM12,509.92 |
| 3. Transport expenses till to-date (and continuing) Estimated at | S\$1,500.00 |
| 4. Pre-trial loss of earnings | to be assessed |
| 5. Pre-trial nursing care | to be assessed |
| 6. Future medical and transport expenses | to be assessed |
| 7. Loss of future earnings and/or loss of earning capacity | to be assessed |

MEMORANDUM

To: UKM Doctors, Malaysia

14-Sep-2017 06:09

From: Lim, Jia Qing

DANNY RAJ A/L MUNIAPPAN

NRIC / FIN: X3732955Z

DOB / Age: 30-Oct-1992 / 25 / Male

Visit Date: 24-Jul-2017 KTPH Ward B86 - 15

Subject: Summary of Injuries on Transfer

Dear colleague,

Thank you for taking over the care of this patient. He was involved in a high impact road traffic accident on 24/7/17 and has since been under the care of Khoo Teck Puat Hospital, Singapore. Our General Surgery, Urology and Orthopaedics teams have been heavily involved in his care. We greatly appreciate your assistance in continuing care and treatment for this patient. As a follow up from the previous memo provided, here is the most updated version of his injuries sustained and our respective treatment plans.

Issues by region:

Head

1. Subarachnoid haemorrhage
- Subsequent CT scans showed interval resolution and evolution of bleeding sites
- GCS stable at 14-15 (confusion) with no neurological signs while in the ward
- Plan: For conservative management and monitoring of GCS

Neck and Spine

1. C7-T3 avulsion fractures of spinous processes
2. Sacral spine fracture
- No spinal cord involvement
- Plan: For conservative management

Chest

1. Pulmonary contusion
2. 1st right rib and 2nd left rib fractures
- Patient saturated well on room air in the ward, asymptomatic
- Plan: For conservative management

3. Left Pneumothorax

- Underwent chest tube insertion x2 (27/7, 30/7) and pigtail drain insertion (6/8) for treatment of pneumothorax
- Pigtail drain removed on 16/8/17
- Patient saturated well on room air after, asymptomatic
- Plan: Resolved issue

Abdomen and Pelvis

1. Open Book Pelvic fracture with internal iliac injury
- Underwent angioembolisation, peritoneal packing and ext fix of pelvis (24/7), Removal of extraperitoneal packs (26/7), Angioembolisation of bilateral internal iliac branches (27/7), Angioembolisation of circumflex artery (29/7)
- external fixation of pelvic fracture done in view of infected abdomen wound and urinary fistula
- Hb currently stable, no more active bleed. Pelvic fracture still on external fixation
- Plan: For removal of external fixator at the same time as the external fixator for left radius (see below). Daily dressing change with chlorohexidine to external fixator pin site dressing.

2. Midline laparotomy wound site infection

- Underwent wound exploration and debridement on 3/8, with subsequent application of negative pressure dressing.
- Wound healing well, currently on Aquacel Ag dressing

Plan: To await healing with regular wound dressing.

3. Inferior Vena Cava Filter insertion(1/8)

- Inserted in view of prolonged immobility, prophylaxis for venous thromboembolism.
- Model: Cook Celect Vena Cava filter

Plan: To consider removal in 3 month's time from 1/8/17 should there no longer be risk of venous thromboembolic event.

Urogenital Tract

1. Bulbar Urethra Hematoma complicated by Pseudomonas UTI

2. Vesicocutaneous Fistula

- Leak noted in the suprapubic region intraoperatively on 15/8/17
- Also noticed haemopurulent urine with debris draining from existing indwelling catheter
- Indwelling catheter inserted by Urology intraoperatively and left inside for drainage of the bladder
- Urine culture grew Pseudomonas (sensitive to piptazo, gentamicin, ciprofloxacin)
- Started on IV piptazo before switching to IV meropenem in view of wound culture results from left tibial wound culture
- Urostomy bag attached to fistula opening to monitor drainage
- Fistula and IDC output monitored separately
- Last IDC change on 10/9/17, Urostomy output has been 0 since 12/9/17

Plan: To keep indwelling catheter in place to drain bladder while awaiting healing of urethra as well as closure of fistula. A cystogram may be conducted once urostomy output remains consistently at 0 to check for healing of fistula tract.

3. Scrotal hematoma

- US testes: No sonographic evidence of testicular torsion or rupture. Large scrotal hematoma seen.

Plan: For conservative management

Left Arm

1a. Left distal humerus fracture

- Underwent left distal humerus wound and bone debridement (21/8);
- Left distal humerus fracture treated with cast; since recurrent UTI and sepsis; clinical situation discussed with family and also within Orthopaedics department
- Plan: To treat with slab, osteotomy at a later date when more stable

1b. Distal radius fracture

- Underwent external fixation of left distal radius (26/7),
- Currently still on left radius external fixator
- Plan: For external fixation of radius to be removed with pelvic external fixation

Left Leg

1. Left tibia open fracture s/p frame fixation and reverse hemisoleus flap

1.1 Complicated by flap necrosis

- Underwent external fixation of left tibial fracture (24/7) and application of negative pressure dressing (26/7)
- Hemisoleus flap used to replace tissue loss on 11/8
- Flap noticed to be unhealthy and negative pressure dressing reapplied to area.
- Wound culture grew ESBL Klebsiella and Pseudomonas, thus patient started on IV meropenem
- Completed D14 of meropenem after wound inspection done on 10/9/17.
- > Residual defect size 3x2mm, wound generally clean
- > Wound culture (10/9/17): scanty pseudomonas from slough of wound
- Currently still on external fixation with ring fixator

Plan: For split skin graft when wound ready and frame adjustment as required; for PO ciprofloxacin on discharge for Pseudomonas wound c/s

Right Leg

1. Right foot 5th metatarsal fracture

Plan: For conservative management with. To keep non-weightbearing for 6 weeks from 27/8/17

2. Right thigh wound

- Underwent wound debridement and negative pressure dressing
- Wound closed on 15/8

Plan: Issue resolved.



Khoo Teck Puat Hospital
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klph.com.sg

Other issues

1. Altered Mental State

- Patient treated with Quetiapine initially and PRN haloperidol
 - Cognitive rehabilitation ongoing, patient clinically more oriented in ward with less episodes of confusion.
- Plan: To continue with cognitive rehabilitation and off psychotropics when no longer required

We hope this memo will serve useful for the continued treatment of this patient. Should you have any further queries, please feel free to get in touch with our doctors.

Thank you very much.


✍

On behalf of Mr Anil Rao

Consultant, General Surgery

Khoo Teck Puat Hospital

Best regards,



Dr. Lin, Jia Qing

MCR: P0252J

CONFIDENTIAL

Your Ref : AK-00178-12-18-BI-(SG)-SD-AN-K
Our Ref : 2019-7908-0

24 September 2019

DAVE ANAN
D3-1-16,
Block D3 Solaris Dutamas,
NO.1, Jalan Dutamas 1,
50480 Kuala Lumpur



Dear Sirs,


Through: Head, Acute and Emergency Care Centre, Khoo Teck Puat Hospital,

NAME : DANNY RAJ MUNIAPPAN
NRIC NO : G6986437L

The above-mentioned patient was seen on 24 July 2017 at the Acute and Emergency Care Centre of Khoo Teck Puat Hospital. He was attended to by Dr Tan, Chin Hung Mark.

The patient was a motorcyclist involved in a road traffic accident. He was flung 3 or 4 meters. He was drowsy and tachycardia. He was intubated. Xrays showed a mildly displaced fracture of his pelvis, involving the right superior pubic ramus and widening of the pubic symphysis. CT trauma angiogram showed a large haematoma in the left groin with active extravasation, pelvic fractures and mild pulmonary contusion in the right lung. CT scan of his brain showed subarachnoid haemorrhage with tiny haemorrhagic foci in the inferior aspect of the left basal ganglia and left temporal lobe. CT scan of his spine showed C7 to T3 avulsion fractures of the spinous processes with distraction of the fracture fragments. There were fractures of the first right rib and second left rib. Fractures through the entire sacral spine were seen, with a displaced fracture of the coccygeal 1 vertebra. Pubic rami fractures with diastasis of the symphysis pubis and left sacroiliac joint were noted. He was admitted to the surgical intensive care unit and sent for operative management.

Impression: traumatic shock



Dr Lin Yingcui Annette
Resident Physician
Acute and Emergency Care Centre
Khoo Teck Puat Hospital
MCR: 17150F

The above findings are with reference to clinical notes done by Dr Tan, Chin Hung Mark.

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Your Ref : AK-00178-12-18-BI-(SG)-SD-AN-K
Our Ref : 2019-7881-0

26 September 2019

Dave Anan
Advocates & Solicitors
D3-1-16 Block D3, Solaris Dutamas
No 1, Jalan Dutamas 1
50480 Kuala Lumpur

MEDICAL REPORT FOR DANNY RAJ MUNIAPPAN – G698643L

To Whom It May Concern:

The abovenamed was a 24-year-old male who was a motorcyclist who rear-ended a stationary car at high speed and subsequently flung 3-4 metres on 24 July 2017. He was managed at Khoo Teck Puat Hospital and eventually discharged on 14 Sept 2017 after having gone through multiple surgeries.

His main injuries sustained were open fractures of his left upper and lower limb as well as pelvic open book fracture needing angioembolization, and exploratory laparotomy on the same day.

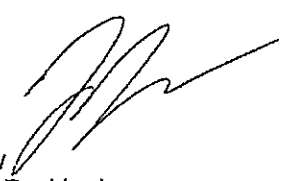
The urologist on call was called in on the same day (24 July 2017) for difficult urethral catheterisation. Flexible cystoscopy and retrograde cystogram on the same day did not show any bladder or urethral injuries. However, the bladder was displaced to the right likely due to extra-peritoneal haematoma. He had also developed a hemoscrotum which has since resolved on subsequent inpatient review by the Urology team. To note was on the same day as his trauma, patient also had bilateral internal iliac artery angioembolization to stop his pelvic bleeders. This may be a consideration for impaired vascularity of the bladder for future repair and for erectile dysfunction in future.

Patient was left on an indwelling urethral catheter which was removed in surgical intensive care unit about 2 weeks later. On the same day as removal patient developed a vesicocutaneous fistula which was noted to be draining from his left inguinal region. In view of this being a likely extraperitoneal fistula tract, he has been maintained on his urinary catheter since then. Daily drainage from his fistula tract has been 0ml the past 2 days on 11 and 12 september. The last IDC change was done on 10 September 2017 by our Urology team. We had written a follow-up letter to the Urologist in Malaysia to follow up on the vesico-cutaneous fistula.


The patient was discharged from Khoo Teck Puat Hospital on 14 Sept 2017 and transferred to UKM Malaysia for further treatment of his injuries. He has not been seen in our Specialist Outpatient Clinic since then.

Thank you.

Best Wishes,
Dr Jeffrey Leow
Urology Senior Resident
Department of Urology
Khoo Teck Puat Hospital



Dr Molly Eng
Head & Senior Consultant
Department of Urology
Khoo Teck Puat Hospital
MCR No. 60803J



CONFIDENTIAL

Your Ref : AK-00178-12-18-BI-(SG)-SD-AN-K
Our Ref : 2019-7883-0

14 October 2019

DAVE ANAN
D3-1-16,
BLOCK D3 SOLARIS DUTAMAS,
NO.1, JALAN DUTAMAS 1,
50480 KUALA LUMPUR

Through: Head, Department of Orthopaedic Surgery, KTPH

Dear Sir/Madam,

**MEDICAL REPORT FOR DANNY RAJ MUNIAPPAN
G6986437L**

The above patient admitted to Khoo Teck Puat hospital after a road traffic accident on 24/7/2017. Patient was a motorcyclist who rear ended stationery car at high speed and subsequently flung 3-4 meters.

He suffered from the following Orthopaedic injuries

1. Pelvic open book fracture, with minimally displaced sacral fracture and coccygeal fracture
2. Left tibia open fracture
3. Left distal humerus fracture
4. Left distal radius fracture
5. Right 5th metatarsal fracture
6. C7 to T3 spinous process fracture
7. Right thigh open wound
8. Right forearm laceration

Due to hemodynamic instability, the patient underwent laparotomy and extraperitoneal, packing and bilateral internal iliac branch angiembolization, cystoscopy with insertion of indwelling urinary catheter by Urology and external fixation of the pelvic open book fracture by Orthopedics Surgery on admission (24/7/2017).

The following are the procedures that was undertaken for each of his Orthopaedic injuries

1. Pelvic open book fracture, with minimally displaced sacral fracture and coccygeal fracture
 - a. Underwent angioembolization, peritoneal packing and external fixation of pelvic 24/07/2017
 - b. Removal of extraperitoneal packs 26/07/2017
 - c. Angioembolization of bilateral internal iliac branches 27/07/2017
 - d. Angioembolization of circumflex artery 29/07/2017
 - e. Adjustment of external fixation of pelvic and pin sites wound debridement on 03/08/2017
 - f. Change from high route to low route external fixation of pelvic due to abdominal wound infection as definitive fixation on 08/08/2017
 - g. Patient will require removal of external fixator at the same time as the external fixator for left radius

**MEDICAL REPORT FOR DANNY RAJ MUNIAPPAN
G6986437L**

2. Left tibia open fracture
 - a. Underwent wound debridement external fixation of left tibia fracture on 24/07/2017
 - b. Underwent Wound debridement and application of negative pressure dressing 26/07/2017
 - c. Underwent relook wound debridement and application of negative pressure dressing on 08/08/2017
 - d. Change from uniplanar external fixation to ring external fixation as definitive fixation and hemisoleus flap for soft tissue coverage on 11/08/2017
 - i. This was complicated by flap infection which was treated with antibiotic
 - e. Underwent flap excision and debridement due to flap necrosis on 25/08/2017
 - f. Underwent further Wound debridement and application of negative pressure dressing on 30/08/2017 and 10/09/2017
 - g. Patient will eventually need soft tissue coverage (such as split thickness skin graft) once the wound clean and infection free
3. Left distal humerus fracture
 - a. Underwent manipulation, closed reduction and application of backslab on 15/08/2017
 - b. Underwent left distal humerus wound and bone debridement and closure on 21/08/2017
 - c. Due to recurrent urinary tract infection and sepsis, treatment plan was discussed with family. Family agreed to treat with backslab and with plans for corrective osteotomy at a later date when patient is more stable
4. Left distal radius fracture
 - a. Underwent external fixation of left distal radius on 26/07/2019
 - b. Patient will require removal of external fixation of radius
5. Right 5th metatarsal fracture
 - a. Treated conservatively with non-weight bearing for 6 weeks from 27/08/17
6. C7-T3 avulsion fractures of spinous processes and Coccygeal 1 fracture
 - a. Treated conservatively
7. Right thigh open wound
 - a. Underwent wound debridement and application of negative pressure dressing 03/08/2017
 - b. Underwent relook wound debridement and application of negative pressure dressing on 08/08/2017
 - c. Wound was debrided and closed on 15/08/2017
8. Right forearm laceration
 - a. Underwent wound debridement on 24/07/2017
 - b. And subsequent wound closure on 26/07/2017

In view of financial constraint, the patient's family decided for transfer of medical care to University Kebangsaan Malaysia Medical Centre, Malaysia. The patient was transferred on 14/09/2017 to continue medical treatment for his injuries.

Yours sincerely




Dr Lynn Thwin
Senior Resident
Department of Orthopaedic Surgery
Khoo Teck Puat Hospital

CONFIDENTIAL

Your ref : AK-00178-12-18-BI-(SG)-SD-AN-K
Our ref : 2019-7884-0

29 October 2019

DAVE ANAN
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50480 KUALA LUMPUR


Departmental Lead, Dept of Surgery

Adj Asst Prof Jerry Goo Tiong Thy
MB BCH BAO (Ire), MRCS (Edin),
MMed (Surgery), FRCS (Edin)
Consultant
Department of Surgery
Khoo Teck Puat Hospital
MCR No. M12715I

Through : Departmental Lead, Department of Surgery, KTPH

NAME : DANNY RAJ MUNIAPPAN
NRIC : G6986437L

The above patient was admitted under the care of Dr Anil Dinkar Rao, Department of General Surgery, Khoo Teck Puat Hospital, on 24th July 2017, after a road traffic accident on the same day. He was monitored in the Surgical Intensive Care Unit due to severe polytrauma.

He suffered the following injuries:

1) Intracranial haemorrhage

Computed tomography of the brain on 24th July 2017 showed subarachnoid haemorrhage in bilateral tentorium region and possible haemorrhagic foci in left basal ganglia and left temporal lobe.

He was seen by the inpatient Neurosurgery team and advised for conservative management. An intracranial pressure monitoring probe was placed. Repeat computed tomography of the brain on 25th July 2017, 27th July 2017, 3rd August 2017, 14th August 2017, were largely stable.

2) C7 to T3 spinous process fractures

Computed tomography on 24th July 2017 showed C7 to T3 avulsion fractures of the spinous processes with distraction of the fracture fragments. He was reviewed inpatient by the Spine-Orthopaedic Surgery team and planned for conservative management.

3) Bilateral rib fractures with lung contusions subsequently complicated by left pneumothorax

Computed tomography on 24th July 2017 showed 1st right rib undisplaced fracture posteriorly, 2nd left rib fracture posteriorly, and mild contusion at posterior segment of right upper lobe and superior segment of right lower lobe.

He was noted to have a left pneumothorax during X-rays on 27th July 2017. He underwent chest tube insertion on 27th July 2017, 30th July 2017, and pigtail drain insertion on 6th August 2017, which was subsequently removed on 16th August 2017 after resolution of pneumothorax.

4) Multiple pelvic fractures with open-book pelvic fracture complicated by pelvic haematoma

Computed tomography on 24th July 2017 showed right superior and inferior pubic rami fractures, open book pelvic fracture involving symphysis pubis and left sacroiliac joint, longitudinally oriented fractures through entire sacral spine involving posterior elements, displaced fracture of coccygeal vertebrae. The scan also showed a large haematoma in the left groin with active extravasation, with a subcutaneous haematoma is also seen in the left lower abdomen groin extending to the left scrotum, and active extravasation noted at the root of the penis.

He underwent emergent angioembolisation, trauma laparotomy, preperitoneal packing and external fixation of pelvis on 24th July 2017. Intraoperative findings were of a large amount of blood in the pelvis at the pre-peritoneal plane mostly at the left side, dissecting peritoneal plane. On-table angiogram by Interventional Radiology was performed with findings of active extravasation from branches of bilateral internal pudendal arteries. Selective embolization of the internal pudendal arteries was performed with micro-coils and gelfoam slurry followed by non-selective embolization of bilateral anterior divisions of internal iliac arteries.

He subsequently underwent relook laparotomy and removal of extraperitoneal packs with closure of abdominal wound on 26th July 2017, with nil further intra-abdominal bleeding seen.

He underwent angioembolisation of bilateral internal iliac branches on 27th July 2017, with findings of transection of small branch of anterior branch of left internal iliac artery, and possible arteriovenous fistula from a small branch of anterior branch of right internal iliac artery, which were both embolized.

He underwent repeat angioembolization on 28th July 2017, with findings of multiple extravasations of right internal iliac obturator branch, small point extravasation with arteriovenous shunting of left common femoral artery branch, and extravasation from left obturator artery; all of the above were embolized.

He underwent repeat angioembolization on 29th July 2017, with findings of small focal active blush present from a distal right iliac branch (posterior division branch), which was embolized.

This was complicated by infection of the midline laparotomy wound, for which he underwent wound exploration and debridement on 3rd August 2017, with subsequent application of negative pressure dressing and continuation of antibiotic therapy.

He also underwent pelvic external fixation pin sites wound debridement and adjustment of pelvic external fixators on 3rd August 2017 at the same sitting, and adjustment of pelvic external fixators on 8th August 2017.

5) Bulbar urethra hematoma, vesicocutaneous fistula complicated by urinary tract infection, scrotal haematoma

He underwent flexible cystoscopy and retrograde cystogram on 24th July 2017, which showed chiefly a small hematoma at bulbar urethra likely from attempted catheter insertion. He was noted on 15th August 2017 to have suprapubic sinus draining urine. He was seen by the inpatient Urology team and indwelling catheter was inserted, aspirated 100ml hemopurulent urine with debris, and a gentle washout done until clear urine outflow. Urine cultures grew *Pseudomonas* and culture-directed antibiotic therapy with IV piperacillin-tazobactam was initiated. He was placed on a urostomy bag and planned for recheck of fistula tract with cystogram at later date when urostomy output decreased.

Ultrasound testes on 25th July 2017 showed no sonographic evidence of testicular torsion or rupture, and a large scrotal hematoma was seen. The scrotal haematoma was conservatively managed.

6) Left upper limb fractures

X-rays of the left upper limb on 24th July 2017 showed fractures of the distal end of the humerus and distal end of radius. He was reviewed inpatient by the Orthopaedic Surgery team. He underwent left humerus manipulation and reduction on 15th August 2017, left distal humerus wound and bone debridement on 21st August 2017, and the arm was placed on a backslab. He underwent external fixation of left distal radius 26th July 2017, and adjustment of left distal radius external fixator on 3rd August 2017.

7) Left lower limb fractures

He was reviewed inpatient by the Orthopaedic Surgery team. He underwent external fixation of left tibial and fibular fractures on 24th July 2017 and repeat debridement and application of negative pressure dressing on 26th July 2017, repeat debridement application of negative pressure dressing on 3rd August 2017, 8th August 2017, 11th August 2017. He underwent ring fixator placement and hemisoleus flap on 11th August 2017 in light of a large tissue defect. This was complicated by flap necrosis on 21st August 2017.

He underwent left lower limb wound debridement and application of negative pressure dressing on 25th August 2017, repeat debridement and application of negative pressure dressing on 30th August 2017, 10th September 2017. Wound culture grew *Klebsiella* and *Pseudomonas* species and intravenous meropenem was started as targeted antibacterial therapy.

8) Right lower limb 5th metatarsal fracture and right thigh degloving wound.

X-rays of the right foot on 27th July 2017 showed a mildly displaced fracture at the neck of 5th metatarsal bone. He was reviewed inpatient by the Orthopaedic Surgery team. He was planned for conservative treatment to keep non-weightbearing for 6 weeks.

He was noted to have a right thigh wound about 10 by 8 cm in size, and was reviewed inpatient by the Orthopaedic Surgery team. He underwent wound debridement of degloving right thigh wound and negative pressure dressing on 3rd August 2017, repeat debridement and negative pressure dressing on 8th August 2017, and final debridement and closure of right medial thigh wound on 15th August 2017.

9) Right upper limb lacerations

He was reviewed inpatient by the Orthopaedic Surgery team. He underwent washout of multiple lacerations over the extensor aspect of the right forearm on 24th July 2017, repeat debridement and dressings on 26th July 2017.

After the patient's emergent medical treatment was performed and patient had stabilized, patient's family requested for transfer to another institution to complete treatment due to financial concerns. The patient was discharged well on 14th September 2017 via ambulance transport to Universiti Kebangsaan Malaysia Medical Centre, Malaysia.

: Regards,



DR KANG MINLI
 STAFF PHYSICIAN
 DEPARTMENT OF SURGERY
 KHOO TECK PUAT HOSPITAL



HOSPITAL SHAH ALAM
PERSIARAN KAYANGAN
SEKSYEN 7, 40000 SHAH ALAM

SELANGOR DARUL EHSAN

SULIT

Tel. : 03 - 5526 3000 / 03 - 5526 3400

Fax: 03 - 5526 3202

Laporan Perubatan (Medical Report)
Kementerian Kesihatan Malaysia

Butiran Pesakit (*Patient Particulars*):

Nama Pesakit (*Name of Patient*): DANNY RAJ A/L MUNIAPPAN

No. K/P (I/C No.): 921030-07-5297

No. Passport (*Passport No*) :

MRN: SA 253476

Umur (*Age*) : 26

Jantina (*Sex*): MALE

Tarikh masuk wad atau menerima rawatan buat kali pertama (*Date of admission or receiving treatment for the first time*): 23.10.18

Tempat menerima rawatan (*Place where patient received treatment*):

☒

Jabatan Kecemasan (*Emergency Department*)

☒

Klinik Pakar (*Specialist Clinic*)

Wad (*Ward*):

☒

Tarikh discaj dari wad atau meninggal dunia (*Date of discharge of death*): 9.11.18

Disiplin (*Discipline*): Orthopedic

Sejarah (*History*):

This is a 26 year old Indian male. Alleged MVA on 24.7.17 where he sustained fracture of the let tibia and interlocking nail was done at HUKM.

Pemeriksaan Fizikal (*Physical Examination*):

Alert

LEFT LOWER LIMB

Minimal serous discharge from wounds

DPA/PTA +


Unable to dorsiflex ankle

Unable to extend great toe\

Sensation intact

CRT < 2s

SULIT



1. Participation 1974-1980
 - participation 1974
 - participation 1980

UNIT LAPORAN PERUBATAN

Rujukan: UKM HTM.14/175/2

Tarikh: 03/06/2019

TETUAN DAVE ANAN

D3-1-16
BLOCK D3
SOLARIS DUTAMAS
NO 1 JALAN DUTAMAS 1
50480 KUALA LUMPUR

Tuan/Puan,

PERMOHONAN LAPORAN PERUBATAN

- DANNY RAJ, MUNIAPPAN (MRN: N689436)

Dengan hormatnya izinkan saya merujuk kepada perkara di atas dan permohonan tuan/puan bertarikh 25/04/2019 adalah berkaitan.

2. Adalah dimaklumkan bahawa laporan perubatan bagi pesakit di atas telah disediakan oleh pakar/pegawai perubatan yang berkenaan. Bersama-sama ini disampaikan satu (1) salinan laporan perubatan pesakit tersebut seperti permohonan tuan/puan.

3. Resit bayaran penyediaan laporan perubatan bernilai RM200.00 adalah berkaitan. Untuk sebarang permasalahan dan pertanyaan sila hubungi pihak kami di talian 03-9145 7779/5685/5686/8203.

Sekian, terima kasih.

Yang benar,



Ketua Jabatan Maklumat Kesihatan
HCTM, Pusat Perubatan UKM



MS ISO 9001:2015 Cert. No. : QMS 01547

UNIT LAPORAN PERUBATAN, JABATAN MAKLUMAT KESIHATAN
HOSPITAL CANSOLOR TUANKU MUHRIZ, UNIVERSITI KEBANGSAAN MALAYSIA,
Arau B, Blok Canselor Tuanku Muhriz, Jalan Yaacob Latif, Bandar Tun Razak, 56000 Cheras, Kuala Lumpur
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Tarikh: May 29, 2019

Rujukan kami: HUKM-MRN N689436

Rujukan tuan: 6610

Tetuan Dave Anan,
D3-1-16, Block D3,
Solaris Dutamas,
No 1 Jalan Dutamas 1,
50480 Kuala Lumpur

Tuan,

NEUROSURGERY MEDICAL REPORT

PATIENT : DANNY RAJ MUNIAPPAN

NRIC : 921030075297

MRN : N689436

The above named patient was transferred to the Hospital Universiti Kebangsaan Malaysia (HUKM) on 14th September 2017 from Hospital Khoo Teck Puat in Singapore following an alleged motor vehicle accident. He was discharged on the 10th November 2017.

Danny Raj was allegedly involved in an accident on the 24th July 2017 at approximately 1020 hours along Road 1 Seletar Expressway in Singapore. The patient has no recollection of the event but according to the referral letter, he was a motorcycle rider and his motorcycle hit the back of a stationary car. He was thrown off the bike approximately 4 meters to the front. He had loss of consciousness. He was taken to Khoo Teck Puat hospital in Singapore. From the neurosurgical point of view his GCS was 8/15 (E1V2M5), his pupils were equal and reactive. He was intubated for airway and cerebral protection. The CT scan showed traumatic subarachnoid bleed. Interval CT scans done in Singapore showed resolution of bleed. He was managed conservatively by the neurosurgeons there. His GCS improved to 15 during his admission there.

His other injuries were extensive and were managed by different teams such as orthopaedics, general surgery and urology.

Injuries:

- 1) Open book pelvic fracture with internal iliac vessel injury
- 2) C7 to T3 avulsion fracture of spinous process
- 3) Left distal humerus and distal radius fracture
- 4) Open left tibial fracture

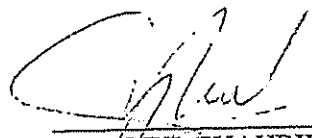


Pemenang Anugerah Kualiti Perdana Menteri 2006
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- 5) Right foot 5th metatarsal fracture
- 6) Pulmonary contusion with 1st right rib and 2nd left rib fractures
- 7) Left pneumothorax
- 8) Bulbar urethral haematoma with vesicocutaneous fistula
- 9) Scrotal haematoma

On arrival, his GCS was 15/15. Neurologically he had no weakness and was obeying command. His cranial nerves were intact. He had no neurological deficit. There was no active intervention required from neurosurgery. His care was taken over by the orthopaedic and urology team. He was transferred to the orthopaedic ward on the 15th September 2017. He was referred to the rehabilitation team to assist in his recovery. As he did not have any neurological deficit during his stay he was discharged from neurosurgical care. He was not seen in the neurosurgical follow up. He was admitted multiple times under the orthopaedic, plastic surgery and urology team for further management of his multiple injuries.

Thank you.



DR ANNUL SYAHRILFAZLI JAAFAR

MPM 39311

Pakar Bedah Neurosurgeri dan Pensyarah Kanan
Unit Neurosurgeri, Jabatan Surgeri
Universiti Kebangsaan Malaysia

s.k. Fail Pesakit

DATU DR ANNUL SYAHRILFAZLI BIN DATUK JAAFAR DIMP
 MRCG (Shireh) MRCS (Edinburgh) MSc (UK) GCOT (Malbourne)
 Consultant Neurosurgeon/Senior Lecturer/Clinical Education
 MPM 39311
 Neurosurgical Unit, Department of Surgery
 Hospital Consultant Tuaran Mahaz
 UTM Medical Centre



Pemenang Anugerah Kualiti Perdana Menteri 2006
Winner of Prime Minister's Quality Award 2006

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 Telefon: 03-9170 2318 / 2316 / 2315 / 2314 / 2313 / 2312 / 2311 / 2310 / 2309 / 2308 / 2307 / 2306 / 2305 / 2304 / 2303 / 2302 / 2301 / 2300 / 2299 / 2298 / 2297 / 2296 / 2295 / 2294 / 2293 / 2292 / 2291 / 2290 / 2289 / 2288 / 2287 / 2286 / 2285 / 2284 / 2283 / 2282 / 2281 / 2280 / 2279 / 2278 / 2277 / 2276 / 2275 / 2274 / 2273 / 2272 / 2271 / 2270 / 2269 / 2268 / 2267 / 2266 / 2265 / 2264 / 2263 / 2262 / 2261 / 2260 / 2259 / 2258 / 2257 / 2256 / 2255 / 2254 / 2253 / 2252 / 2251 / 2250 / 2249 / 2248 / 2247 / 2246 / 2245 / 2244 / 2243 / 2242 / 2241 / 2240 / 2239 / 2238 / 2237 / 2236 / 2235 / 2234 / 2233 / 2232 / 2231 / 2230 / 2229 / 2228 / 2227 / 2226 / 2225 / 2224 / 2223 / 2222 / 2221 / 2220 / 2219 / 2218 / 2217 / 2216 / 2215 / 2214 / 2213 / 2212 / 2211 / 2210 / 2209 / 2208 / 2207 / 2206 / 2205 / 2204 / 2203 / 2202 / 2201 / 2200 / 2199 / 2198 / 2197 / 2196 / 2195 / 2194 / 2193 / 2192 / 2191 / 2190 / 2189 / 2188 / 2187 / 2186 / 2185 / 2184 / 2183 / 2182 / 2181 / 2180 / 2179 / 2178 / 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2034 / 2033 / 2032 / 2031 / 2030 / 2029 / 2028 / 2027 / 2026 / 2025 / 2024 / 2023 / 2022 / 2021 / 2020 / 2019 / 2018 / 2017 / 2016 / 2015 / 2014 / 2013 / 2012 / 2011 / 2010 / 2009 / 2008 / 2007 / 2006 / 2005 / 2004 / 2003 / 2002 / 2001 / 2000 / 1999 / 1998 / 1997 / 1996 / 1995 / 1994 / 1993 / 1992 / 1991 / 1990 / 1989 / 1988 / 1987 / 1986 / 1985 / 1984 / 1983 / 1982 / 1981 / 1980 / 1979 / 1978 / 1977 / 1976 / 1975 / 1974 / 1973 / 1972 / 1971 / 1970 / 1969 / 1968 / 1967 / 1966 / 1965 / 1964 / 1963 / 1962 / 1961 / 1960 / 1959 / 1958 / 1957 / 1956 / 1955 / 1954 / 1953 / 1952 / 1951 / 1950 / 1949 / 1948 / 1947 / 1946 / 1945 / 1944 / 1943 / 1942 / 1941 / 1940 / 1939 / 1938 / 1937 / 1936 / 1935 / 1934 / 1933 / 1932 / 1931 / 1930 / 1929 / 1928 / 1927 / 1926 / 1925 / 1924 / 1923 / 1922 / 1921 / 1920 / 1919 / 1918 / 1917 / 1916 / 1915 / 1914 / 1913 / 1912 / 1911 / 1910 / 1909 / 1908 / 1907 / 1906 / 1905 / 1904 / 1903 / 1902 / 1901 / 1900 / 1899 / 1898 / 1897 / 1896 / 1895 / 1894 / 1893 / 1892 / 1891 / 1890 / 1889 / 1888 / 1887 / 1886 / 1885 / 1884 / 1883 / 1882 / 1881 / 1880 / 1879 / 1878 / 1877 / 1876 / 1875 / 1874 / 1873 / 1872 / 1871 / 1870 / 1869 / 1868 / 1867 / 1866 / 1865 / 1864 / 1863 / 1862 / 1861 / 1860 / 1859 / 1858 / 1857 / 1856 / 1855 / 1854 / 1853 / 1852 / 1851 / 1850 / 1849 / 1848 / 1847 / 1846 / 1845 / 1844 / 1843 / 1842 / 1841 / 1840 / 1839 / 1838 / 1837 / 1836 / 1835 / 1834 / 1833 / 1832 / 1831 / 1830 / 1829 / 1828 / 1827 / 1826 / 1825 / 1824 / 1823 / 1822 / 1821 / 1820 / 1819 / 1818 / 1817 / 1816 / 1815 / 1814 / 1813 / 1812 / 1811 / 1810 / 1809 / 1808 / 1807 / 1806 / 1805 / 1804 / 1803 / 1802 / 1801 / 1800 / 1799 / 1798 / 1797 / 1796 / 1795 / 1794 / 1793 / 1792 / 1791 / 1790 / 1789 / 1788 / 1787 / 1786 / 1785 / 1784 / 1783 / 1782 / 1781 / 1780 / 1779 / 1778 / 1777 / 1776 / 1775 / 1774 / 1773 / 1772 / 1771 / 1770 / 1769 / 1768 / 1767 / 1766 / 1765 / 1764 / 1763 / 1762 / 1761 / 1760 / 1759 / 1758 / 1757 / 1756 / 1755 / 1754 / 1753 / 1752 / 1751 / 1750 / 1749 / 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Hospital Canselor Tuanku Muhriz

UNIT LAPORAN PERUBATAN

Rujukan: UKM HTM.14/175/2
Tarikh: 23/07/2019

TETUAN DAVE ANAN

D3-1-16
BLOCK D3
SOLARIS DUTAMAS
NO 1 JALAN DUTAMAS 1
50480 KUALA LUMPUR

Tuan/Puan,

PERMOHONAN LAPORAN PERUBATAN

- **DANNY RAJ, MUNIAPPAN (MRN: N689436)**

Dengan hormatnya izinkan saya merujuk kepada perkara di atas dan permohonan tuan/puan bertarikh 25/04/2019 adalah berkaitan.

2. Adalah dimaklumkan bahawa laporan perubatan bagi pesakit di atas telah disediakan oleh pakar/pegawai perubatan yang berkenaan. Bersama-sama ini disampaikan satu (1) salinan laporan perubatan pesakit tersebut seperti permohonan tuan/puan.

3. Resit bayaran penyediaan laporan perubatan bernilai RM200.00 adalah berkaitan. Untuk sebarang permasalahan dan pertanyaan sila hubungi pihak kami di talian 03-9145 7779/5685/5686/8203.

Sekian, terima kasih.

Yang benar,

Ketua Jabatan Maklumat Kesihatan
HCTM, Pusat Perubatan UKM



MS ISO 9001:2015 Cert. No. : QMS 01547

UNIT LAPORAN PERUBATAN, JABATAN MAKLUMAT KESIHATAN
HOSPITAL CANSOLOR TUANKU MUHRIZ, UNIVERSITI KEBANGSAAN MALAYSIA,
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Mengilham Harapan, Mendapat Masa Depan - Inspiring Futures, Nurturing Possibilities



Pusat Perubatan UKM / UKM Medical Centre

LAPORAN PERUBATAN (MEDICAL REPORT)

Butiran Pesakit (Patient Particulars)

Nama pesakit (Name of patient): Danny Raj Muniappan

No. K/P (I/C No.) : 921030075297 MRN : N689436

Umur (Age) : 25 Jantina (Sex) : MALE

Tempat menerima rawatan (Place where patient received treatment) : Trauma Ward HUKM

Tarikh menerima rawatan: 14/9/2017-10/11/2017, 17/11/2017-11/12/2017, 2/2/2018-5/2/2018, 23/7/2019 – 26/7/2018 (4 admissions)

Disiplin (Discipline) : Department of Orthopedic, Department of Surgery

Sejarah (History) :

Patient had an alleged motor vehicle accident in Singapore on 24th July 2017. His motorbike rammed into stationary car at high speed and he was flung 3-4 meters away. Patient was intubated on arrival for airway protection (GCS E1V2M5). Patient was treated at Singapore Hospital for:

1. Traumatic Brain injury: Subarachnoid haemorrhage in bilateral tentorial region, with possible hemorrhagic foci in left basal ganglia and left temporal lobe.
2. Open book pelvic fracture with internal iliac injury
 - a. 24/7/2017 – angioembolisation, peritoneal packing and external fixation of pelvis
 - b. 26/7/2017 – removal of extraperitoneal packs
 - c. 27/7/2017 – angioembolisation of bilateral internal iliac branches
 - d. 29/7/2017 – angioembolisation of circumflex artery
3. Pulmonary contusion with 1st right rib and 2nd left rib fractures
4. Left pneumothorax – resolved with chest tube
5. C7 to T3 avulsion fractures of spinous processes – conservative management
6. Left distal humerus and distal radius fracture
 - a. 26/7/2017: external fixation of left distal radius
 - b. 3/8/2017: adjustment of left distal radius external fixation
 - c. 15/8/2017: Manipulation and reduction
 - d. 21/8/2017: left distal humerus wound and bone debridement and closure
7. Open left tibia fracture
 - a. 24/7/2017: wound debridement and external fixation of left tibia fracture



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- b. 26/7/2017: wound debridement and application of negative pressure dressing (VAC).
- c. 11/8/2017: ring fixator and hemisoleus flap
- 8. Vesico-cutaneous fistula
- 9. Scrotal hematoma

Patient was transferred to PPUKM for further treatment.

Pemeriksaan Fizikal (Physical Examination) (on arrival of PPUKM)

- GCS full
- BP112/70, HR82, Afebrile
- Lungs clear
- Abdomen soft, non-tender
- Left scrotal tenderness
- Left upper limb – swelling at the flexor surface (2x3cm) with tenderness
- Left lower limb – slough over the wound

Ujian (Investigation) :

- Hb 10.4 / TWBC 8.1 / Platelet 351
- Na 139 / K 4.2 / Urea 6.7 / Creatinine 54.6
- CRP 5.42
- X-ray of upper limb: Communitied distal radius fracture with intraarticular extension. Suspicious radioulnar joint disruption.
- Cystoscopy: bulbar urethral false track

Diagnosis Mukamat (Final Diagnosis) :

- Surgical site infection of left radius
- Wound infection over left tibia
- Urethral false track

Rawatan (Treatment) :

- Antibiotics
- Urinary catheter
- Multiple incision and drainage, and wound debridment
- Dressing
- Removal of pelvis external fixator – 4/10/2017
- Removal of left upper limb external fixator – 26/10/2017
- Bicolumnar plating of left humerus, ILN of left tibia and split skin grating – 31/10/2017

Laporan disediakan oleh (Report prepared by)

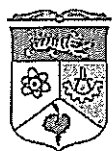


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Dr. Lim Li Yi
MMC 49812
Pakar Bedah
Unit Urologi
JABATAN SURGERI PP UKM

Tandatangan(*Signature*)

Nama Penuh(*Full Name*) : Dr. Lim Li Yi
No. K/P (No. I/C) : 841125145972
Tarikh(*Date*) : 8/1/2019
No Pendaftaran Penuh (*MMC No*): 49812
Cop Rasmi (*Official Stamp*) :



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LAPORAN PERUBATAN (MEDICAL REPORT)

Butiran Pesakit (*Patient Particulars*)

Nama pesakit(*Name of patient*) : Danny Raj Muniappan

No. K/P (I/C No.) : 921030-07-5297

MRN : N689436

Umur (*Age*) : 27

Jantina (*Sex*) : male

Tarikh Rawatan Pertama(*Date of first treatment*): 14/9/2017

Tarikh masuk wad (*Date of admission*): 14/9/2017

Tarikh discaj wad (*Date of discharge*): 10/11/2017

Tempat menerima rawatan (*Place where patient received treatment*): PUSAT PERUBATAN
UKM

Disiplin (*Discipline*) :

Orthopaedics and Traumatology

Sejarah (*History*) :

The above name patient was first seen at our centre on 14/9/2017. He was allegedly involved in motor vehicle accident on the same day at approximately .24/7/2017 and was initially treated at Singapore. He sustained polytrauma. The orthopaedic diagnosis that he presented with and treatments that were carried out in Singapore are as follows

- open book fracture of the pelvis
 - external fixation
 - angioembolisation of bilateral internal iliac branches and circumflex artery
- open left distal humerus and distal radius fracture
 - external fixation of the left upper limb
- C3-T3 avulsion fracture

- cervical collar
- open left tibia fracture
 - wound debridement and external fixation
 - application of external ring fixator and soleus flap. However the flap did not survived and required debridement
- closed fracture of the 5th metatarsal of the right foot
 - cast

He was transferred to our centre for continuation of care

Rawatan (*Treatment*)

open book fracture of the pelvis

- continuation of treatment with external fixator

open left distal humerus and distal radius fracture

- plating of left humerus and radius

open left tibia fracture

- interlocking of the left tibia with application of Integra over exposed tibia

Patient was readmitted on

- 17/11/2017 due to left wrist swelling and pain

A diagnosis of surgical site infection of the left distal radius was made. He underwent incision and drainage on 17/11/2017

SSG of the left leg (tibia) on 28/11/2017

- 2/2/2018 with a diagnosis of surgical site infection of the left tibia

Wound debridement was performed on 3/2/2018

- 23/7/2018

The infection over the left tibia did not settle. Options of further management was discussed

Patient later opt to continue treatment at another centre.

Keadaan pesakit ketika kali terakhir berjumpa doktor (*Condition of the patient last seen by the doctor*):

He is able to walk partial weightbearing (patient was seen in rehab clinic)

Tarikh kali terakhir berjumpa doktor (*Date of the patient last seen by the doctor*) :

28/12/2018

Final diagnosis:

- open book fracture of the pelvis
- open left distal humerus and distal radius fracture
- C3-T3 avulsion fracture
- open left tibia fracture
- closed fracture of the 5th metatarsal of the right foot

Complicated with

Surgical site infection of the left distal radius

Infected left tibial implant

Laporan disediakan oleh (*Report prepared by*)



Tanda Tangan (*Signature*)

Nama Penuh (*Full Name*) : Dr Nor Hazla Mohamed Haflah

No. K/P (*No. I/C*) : 710410055378

Tarikh (*Date*) : 19/7/2019

Cop Rasmi (*Official Stamp*) :

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